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DESCRIPTION OF LIMITATIONS

1. Eff. 4-1-93 — Inpatient Hospital Services. Prior authorization is required for services provided outside the state by non-border status providers in non-emergency circumstances, for transplant services and for ventilator dependent services. Other professional services that require prior authorization outside the hospital, often require prior authorization when provided in a hospital.

Other limitations include, but are not limited to: circumstances for private room accommodations; restrictions on non-therapeutic sterilizations; requirements for separate billing of independent professional services; and restrictions to avoid duplicative and unnecessary payments.

2.a. Outpatient Hospital Services. Prior authorization restrictions apply to these services as required by the area of service.

2.b. Rural Health Clinic Services. Services provided by rural health clinics are subject to the same prior authorization requirements and other limitations as applied to covered services in the Medical Assistance Program.

2.c. Eff. 10-1-91 — Federally Qualified Health Centers. Prior authorization and other limitations required for various medical disciplines as described in HSS 107, Wis. Admin. Code are applicable.

2.d. Eff. 10-1-91 — Health Center Ambulatory Services. Prior authorization and other limitations required for various medical disciplines as described in HSS 107, Wis. Admin. Code are applicable.

4.a. Nursing Facility Services. Prior authorization is required for rental or purchase of a specialized wheelchair. Levels of service required are stipulated by the recipient's plan of care, subject to guidelines described in HSS 107.09(3).

4.c. Family Planning Services. Sterilization procedures require prior authorization and informed consent as mandated under federal regulations.

4.b. EPSDT Other Services, continued.

4. School Based Services

School Based Services (SBS) are services that are listed in an eligible student's Individualized Education Program (IEP) that are coverable under one or more of the service categories described in Section 1905(a) of the Social Security Act, and that are necessary to correct or ameliorate defects or physical or mental illnesses or conditions discovered by an EPDST screen.

Service providers shall be licensed under the applicable State practice act or comparable licensing criteria by the State Department of Public Instruction, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them is done by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team. Eligible individuals may obtain covered services from any person qualified to perform the services required, who undertakes to provide the services.

Covered services include physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. Covered services also include nursing services coverable under 42 CFR §440.80, and 42 CFR §440.60 ordered by a licensed physician and performed by a registered nurse or licensed practical nurse, nursing services provided on a restorative basis under 42 CFR §440.130 (d), including services delegated in accordance with the Nurse Practice Act to individuals who have received appropriate training from a registered nurse; personal care services (as known as attendant care services) coverable and performed by individuals qualified under 42 CFR §440.167; psychological, counseling, and social work services performed by licensed practitioners within the scope of practice as defined under state law and coverable as medical or other remedial care under 42 CFR §440.60 or rehabilitative services under 42 CFR §440.130. Assessments are covered as necessary to assess or reassess the need for medical services in a child's treatment plan and must be performed by any of the above licensed practitioners within the scope of practice.

The state has established controls to prevent duplicate services and assure continuity of care when a child receives services from both SBS providers and Medicaid Health Maintenance Organizations (HMOs) or fee-for-service providers. HMOs are responsible for managing medical services for recipients receiving SBS when recipients are in HMOs. SBS and HMO providers are required to sign Memorandums of Understanding setting standards, policies and procedures to avoid duplication of services and coordinate care. Where a child served within the Medicaid fee-for-service system receives SBS, SBS providers are required to document the regular contracts between schools and community providers as appropriate for each child but at least annually. Medicaid monitors service coordination and ensures duplicate services are not provided through prior authorization.

Physical therapy can be provided by physical therapy assistants, aides, and interns under the direction of a qualified physical therapist. Occupational therapy can be provided by occupational therapy assistants, aides, and interns under the direction of a qualified occupational therapist. Speech language services for individuals with speech, hearing, and language disorders can be provided by a speech language pathology assistant and interns under the direction of a qualified speech language pathologist. Audiology can be provided by audiology assistants, interns, and interpreters under the direction of a qualified audiologist.

When services are provided under the direction of a licensed therapist, the licensed must:

- see the beneficiary at the beginning of and periodically during treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout the treatment;
- assume professional responsibility for the services provided under his/her direction and monitors the need for continued services;
- spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensure that individuals working under his/her direction have contact information to permit them direct contact with the supervising therapist as necessary during the course of treatment; and
- maintain documentation supporting the supervision of services and ongoing involvement in the treatment.

5.a. Eff. 4-1-93 Physician's Services. The Department imposes some payment and benefit limitations on some specific physician services. Many of these limitations are based on quantity and frequency, diagnoses, provider specialty, or the place the service is provided. In addition, some procedures require prior authorization and/or a second surgical opinion. Examples of physician services in each of these areas are listed below:

Services with Quantity and Frequency Limitations - Services with quantity and frequency limitations include: evaluation and management visits in the office, outpatient clinic and inpatient hospital nursing home; routine foot care; specific injections; weight alteration programs; fetal monitoring; clozapine management, and multiple surgeries performed on the same day.

Services with Diagnosis Limitations - Services with diagnosis limitations include: certain injections, routine foot care and application of Unna boots.

Services with Provider Specialty Limitations - Provider specialty limitations are imposed on physicians providing obstetric and pediatric services, and those performing evoked potentials testing.

Services with Place of Service Limitations - Place of service limitations are imposed on medication management in the home and on critical or prolonged care provided in the emergency department.

Services that Require Prior Authorization - To insure that a procedure is medically necessary, to demonstrate that the procedure is not primarily cosmetic or for the convenience of the recipient, to assure that the procedure is not experimental in nature, and to allow the Department to determine the treatment is the most cost-effective available, the provider must obtain prior authorization for the following categories of procedures:

1) Surgical or other medical procedures of questionable medical necessity but deemed by the Department to be essential to correct conditions that cause significant impairment to the recipient's interpersonal adjustments or employability;

2) Surgical procedures or medical procedures that the Department deems redundant, outdated or marginally effective;

3) Transplants;

4) Sterilizations (to conform with federal and state regulations and limitations);

5) Temporomandibular surgery.

Second Surgical Opinion - Elective surgeries that require the recipient obtain a second surgical opinion include but are not limited to: cataract extraction; cholecystectomy; hemorrhoidectomy; diagnostic D & C procedures; inguinal hernia repair; hysterectomy; joint replacement, hip or knee; tonsillectomy/adenoidectomy; varicose vein surgery.

5.b. Eff. 10-1-91 Dental Services. The same prior authorization and other limitations required under item #10 and 12.b. apply.

6.a. Eff. 7-1-90 Podiatry Services. Prior authorization is required for electric bone stimulation. Maintenance care is limited to once per 61 day period under certain conditions. For other service limitations, see s. HSS 107.14(3), Wis. Admin. Code. All orthopedic and orthotic services, including repairs, orthopedic and corrective shoes and supportive devices, services correcting "flat feet," and treatment of subluxation of the foot are not covered.

6.b. Eff. 1-1-93 Vision Care Services. (Optometry) Prior authorization is required for certain types of lenses and frames, antiseikonic services, prosis crutch services, low vision services, certain ophthalmological services and vision training. Frames, lenses and replacement parts must be obtained through the volume purchase plan provider, unless prior authorized. Anti-glare coating, spare eyeglasses and sunglasses, and services provided primarily for convenience or cosmetic reasons are not covered.

State: Wisconsin

6.c. Eff. 3-1-86

Chiropractic. Prior authorization is required for services beyond the initial visit and 20 spinal manipulations per spell of illness. Consultations are not covered.

6.d. Eff. 4-1-93

Other Practitioners

Other Nurse Practitioners and Clinical Nurse Specialist Services.
Included are other primary care nurse practitioner and clinical nurse specialist services not covered under item #23. Services are subject to limitations imposed on specific disciplines within the scope of practice of the nurse. These services include medical services delegated by a licensed physician through protocols, pursuant to the requirements set forth in the Wisconsin Nursing Act and the guidelines set forth by the medical examining board and the board of nursing. Other practitioner services are subject to the same limitations imposed on physician services under item #5 to enable the Department to monitor and regulate the following: medical necessity, cost, frequency and place of service.

Medication management includes in-home administration of medications other than those given intraveneously, prefilling syringes for self injection when the recipient is not capable, setting up medications for self-administration, and programming dispensers. Instructing the recipient may be covered when provided in conjunction with these activities but not covered if it is the only activity.

Pharmacists.
Pharmacists may be reimbursed for the administration of the 2009 H1N1 vaccine to the extent permitted by Wisconsin law. The vaccine itself will be provided by the Federal Government and provided free of charge.

Effective 10/01/2009

including medication management as defined below

7. Eff. 1-1-92 Home Health Care Services. Home health skilled nursing and therapy services are provided to a recipient who, due to his/her medical condition, is unable to leave home to obtain necessary medical care and treatment and therefore, must receive this care at home. However, a recipient who can leave the home but cannot reasonably be expected to obtain this care outside the home, or cannot obtain medically necessary services from an appropriate provider outside the home may receive home care. Medically necessary home health aide services are available, irrespective of the recipient's ability to leave his/her residence.

Similar to Medicare, a visit may be of any duration, with prior authorization required after 30 visits of any combination of RN, LPN, home health aide or therapy services, including medication management. Skilled nursing and therapy services are available for recipients who require less than eight hours of a day with home health aide services provided up to 24 hours a day as the recipient's condition requires. Various limitations apply based on appropriate nursing practices, state licensure, and Medicare/Medicaid certification requirements.

Medication management includes administration of medications other than those given intravenously, prefilling syringes for self injection when the recipient is not capable, setting up medications for self-administration, and programming dispensers. Instructing the recipient may be covered when provided in conjunction with these activities but not covered if it is the only activity.

Eff. 7-1-95

Clozapine Management. Clozapine Management is a covered service when all of the following conditions are met:

- a physician has prescribed clozapine,
- the recipient is currently taking clozapine or has taken it within four weeks,
- the dispensing pharmacy has received prior authorization for clozapine,
- the provider of clozapine management has received prior authorization for that service.

Providers of clozapine management work under the general supervision of a physician or a pharmacist and include Medicaid-certified, licensed pharmacies and Community Support Programs (CSP). Qualified pharmacy staff include pharmacists, nurses, pharmacy technicians and others with equivalent training, knowledge and experience. Qualified CSP professional staff are designated in the approved CSP treatment plan component regarding clozapine management services.

Components of clozapine management include the following services as appropriate:

a. Ensuring the recipient has the required weekly white blood count testing. The provider may draw the blood or transport the recipient to a clinic, hospital, or laboratory to have the blood drawn, if necessary. To perform this service, the provider may travel, if necessary, to the recipient's residence or other places in the community where the recipient is available.

b. Ensuring the blood test results are reported in a timely fashion to the pharmacy dispensing the recipient's clozapine.

c. Ensuring abnormal blood test results are reported to the physician who prescribed the recipient's clozapine.

d. Ensuring the recipient receives medications as scheduled, ensuring the recipient stops taking medication when the blood test is abnormal, if so ordered by the physician, and receives any physician-prescribed follow-up care to ensure that the recipient's physical and mental well-being are maintained.

e. Making arrangements for the transition and coordination of the use of clozapine and clozapine management services between different care locations.

f. Maintaining appropriate records.

6.d. Other practitioners, continued

I. **Medication Therapy Management Services Performed by a Pharmacist**

The Medication Therapy Management (MTM) benefit consists of services that are provided by qualified, licensed pharmacists to members to optimize the therapeutic outcomes of a recipient's medications and reduce costs. These services are delivered in a face-to-face setting. This benefit is voluntary and is available for members in Wisconsin Medicaid, BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, and BadgerCare Plus Core Plan. The MTM benefit will include two types of services:

A. Intervention-Based Services - These are focused interventions between pharmacists and members, such as instructing a patient on using a medication device, filling a pill box for a member, or recommending a change to a member's prescription when the member has an adverse reaction to the medication.

1. The prescriber must approve changes to the member's drug regimen.
2. All members enrolled in a qualifying plan are eligible for this service.
3. Four of the same intervention-based services are reimbursable per member, per rolling year, with the exception of the following services for which there is no annual limit:

- Formulary interchanges
- Therapeutic interchanges
- Tablet-splitting opportunities
- Conversion to an over-the counter product
- Dose consolidation
- Converting a prescription from a one-month supply to a three-month supply (this is limited to one intervention, per drug, per rolling year)

B. Comprehensive Medication Review and Assessment (CMR/A) – These are comprehensive interventions between providers and members. They involve an in-depth, interactive review of the member's medication regimen, health history and lifestyle.

6.d. Other practitioners, continued

I. **Medication Therapy Management Services Performed by a Pharmacist, continued**

1. A member may be eligible for this service if the member meets at least one of the following criteria:
    - Is taking four or more medications used to treat or prevent two or more chronic conditions.
    - Has diabetes.
    - Has recently been discharged from the hospital or a long term care setting.
    - Has experienced health literacy issues.
    - Was referred by a prescriber due to issues that are impacting the member's health.
    - Meets other criteria as defined by the Department.
2. The provider must be certified by a Department-approved certification program before providing a CMR/A.
3. Providers must have a private or semi-private area in which to conduct the CMR/A.
4. One initial assessment and three follow-up assessments are reimbursable per member, per rolling year.

Providers may receive Department approval to exceed annual limits for the intervention-based services and CMR/As for children who are EPSDT-eligible and for members who demonstrate medical need.

7.c. Medical Supplies and Equipment. The Department requires prior authorization or imposes payment and benefit limitations for the repair, modification, rental or purchase of most medical supplies and equipment to enable the Department to monitor and regulate the following: cost, frequency, place where the recipient receives the service, and recipient's medical diagnosis or functional conditions under which the items will be reimbursed. These medical supplies and equipment include, but are not limited to: durable medical equipment, disposable supplies, hearing aid and related materials, and orthoses.

The following medical supplies and equipment are not covered: items that are not primarily medical in nature, are not proven to be therapeutically effective, or do not contribute to the improvement of a recipient's medical or functional condition; and items or features that are primarily for a recipient's comfort and convenience.

7.d. Eff. 3-1-86 Physical, Occupational and Speech Therapy and Audiology Provided by Medical Rehabilitation Facility The prior authorization requirements and other limitations are described below in item #11.

8. Eff. 1-1-92 Private Duty Nursing. Prior authorization is required for all private duty nursing services. These services may be provided only if the recipient requires 8 or more hours of skilled nursing care a day.

9. Eff. 3-1-86 Clinic Services. All prior authorization requirements for services apply as appropriate. Second surgical opinion requirements also apply (see #5 above).

10. Eff. 3-1-96 Dental Services. Dental services are limited to the basic services within each of the following categories: diagnostic services, preventive services, restorative services, endodontic services, periodontic services, fixed and removable prosthodontic services, oral and maxillofacial surgery services, and emergency treatment of dental pain. The following are examples of services not covered:

10. Dental Services. (Continued)

Eff. 10-1-95

dental implants and transplants; services for cosmetic purposes; overlay and duplicate dentures; precious metal crowns; professional visits; drug dispensing; adjunctive periodontal services; alveoplasty and stomoplasty; and non-surgical temporomandibular joint therapy. Several services are provided only in specified circumstances or as referred through a HealthCheck (EPSDT) screen. For other limitations and a listing of those services requiring prior authorization, see the WMAP Dental Provider Handbook, Part B.

11. Physical Therapy and Related Services. Prior authorization is required for physical and occupational therapies, and speech language pathology after 35 treatment days per spell of illness. A spell of illness means a condition characterized by a demonstrated loss of functional ability to perform daily living skills, caused by a new disease, injury or medical condition or by an increase in the severity of a pre-existing medical condition. Servces for recipients who are hospital inpatients or receiving therapy through a home health agency are not subject to this requirement. For audiology, prior authorization is required for speech and aural rehabilitation.

Eff. 3-1-06

Physical therapists provide physical therapy services, occupational therapists provide occupational therapy services, and speech-language pathologists provide speech, hearing and language services. Physical therapists are certified under s. DHS 105.27 and meet the requirements of 42 CFR 440.110 (a). Occupational therapists are certified under s. DHS 105.28 and meet the requirements of 42 CFR 440.110 (b). Speech language pathologists are certified under s. DHS 105.30 and meet the requirements of 42 CFR 440.110 (c). Those who provide services under the direction of the listed therapists are physical therapist assistants, who are certified providers under ch. DHS 105.27, and occupational therapy assistants, who are certified providers under s. DHS 105.28.

12. Prescribed Drugs.

1. Drugs and drug products covered by MA include legend and non-legend drugs and supplies listed in the Wisconsin Medicaid drug index, which are prescribed by a licensed physician, nurse prescriber, dentist, podiatrist, or optometrist or when a physician delegates prescription of drugs to a nurse practitioner or to a physician's assistant.

2. Drugs excluded from coverage include drugs determined to be "less than effective by the FDA, drugs not covered by a federal rebate agreement, experimental drugs or other drugs that have no medically accepted indications, and other items as enumerated in Wisconsin Administrative Code, such as personal hygiene items, cosmetic items, and common medicine chest items.

3. To be a covered service, an over-the-counter drug shall have a signed federal rebate agreement and be listed in the Wisconsin Medicaid drug index. General categories of OTC drugs that are covered include the following: antacids, analgesics, insulins, contraceptives, cough preparations, opthalmic lubricants, iron supplements for pregnant women, and other, medically necessary, cost-effective drug products, including some non-legend products that previously had legend drug status.

Effective 08/15/2003

12.a. Prescribed drugs. continued.

Prior Authorization

1. Prescription drugs may be subject to prior authorization by DHFS to ensure that drugs are prescribed and dispensed appropriately.

2. DHFS determines which prescription drugs may require prior authorization by reviewing the drug(s) for the following: safety; potential for abuse or misuse; narrow therapeutic index; and high cost when less expensive therapeutically equivalent alternatives are available.

3. DHFS will convene a Prescription Drug Prior Authorization Committee comprised of at least two physicians, two pharmacists, and one advocate for Medicaid recipients to review the pertinent scientific literature and make prior authorization recommendations to the Department.

4. As enumerated in Wisconsin Administrative Code, all Schedule III and IV stimulant drugs as listed in the Wisconsin Medicaid Drug Index; enteral and parenteral nutrition products; fertility drugs used for treatment of a condition not related to fertility; impotence drugs used for treatment of a condition not related to impotence; drugs that have been demonstrated to entail substantial cost or utilization problems for the MA program; and drugs produced by a manufacturer that has not signed a federal rebate agreement but which are medically appropriate and cost effective treatment for a recipient's condition as certified by the prescribing provider are subject to prior authorization.

5. To provide economies and efficiencies in the Medicaid program, the state applies the same prior authorization requirements and supplemental rebate provisions utilized in the Medicaid program to its state-sponsored portion of SeniorCare.

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12.a. Prescribed drugs, continued.

6. Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization and for the dispensing of a 72-hour supply of medications in emergency situations.

7. A drug use review program, including prospective and retrospective drug utilization review, has been implemented, in compliance with federal law.

8. Claims management is electronic, in compliance with federal law.

9. The state is in compliance with section 1927 of the Social Security Act. The state will cover drugs of manufacturers participating in the federal rebate program. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers may audit utilization data. The unit rebate amount is confidential and may not be disclosed for purposes other than rebate invoicing and verification.

10. The state will participate in a multi-state pooling program that will negotiate supplemental rebates in addition to federal rebates provided for in Title XIX. This multi-state pooling program is known as The Optimal PDL $olution (TOP$). TOP$ rebate agreements will be separate from the federal rebates. TOP$ supplemental rebates received by the state in excess of those required under the federal drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the federal rebate agreement.

11. A TOP$ rebate agreement for drugs provided to the Medicaid program has been authorized by CMS.

12. Pursuant to 42 USC 1396r-8, the state is establishing a preferred drug list with prior authorization requirements for drugs not included on the preferred drug list.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Agency Wisconsin

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

The following excluded drugs are covered:

☑ (a) agents when used for weight loss

Meredia, Didrex, Phentermine, Ionamin, Diethylpropion, Bontril, and Xenical. Coverage is for both the brand name and generic formulations of the aforementioned weight loss agents.

☐ (b) agents when used to promote fertility (see specific drug categories below)

☐ (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)

☑ (d) agents when used for the symptomatic relief cough and colds

☑ (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride

☑ (f) nonprescription drugs

Prilosec OTC (coverage terminates 4/1/06)

Antacids, analgesics, contraceptives, cough preparations, antihistamines, opthalmic lubricants, iron supplements for pregnant women, and other, medically necessary, cost-effective drug products, including some non-legend products that previously had legend drug status.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency Wisconsin

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)

☑ (h) barbiturates

Effective for dates of service on and after January 1, 2013, barbiturates will become Medicare Part D-covered drugs when used for cancer, epilepsy, or chronic mental health disorder diagnoses. Claims for barbiturates for full benefit dual eligible beneficiaries with these diagnoses should be submitted to Medicare Part D.

☑ (i) benzodiazepines

Effective for dates of service on and after January 1, 2013, benzodiazepines will become Medicare Part D-covered drugs. Claims for benzodiazepines for full benefit dual eligible beneficiaries should be submitted to Medicare Part D.

☑ (j) prescription smoking cessation products (except as Medicare Part D will cover for dual eligibles)

12.b Dentures. Prior authorization is required.

12.c Prosthetic Devices. Prior authorization is required for most prostheses, hearing aids and other medical equipment in the Wisconsin Durable Medical Equipment and Supplies indices, except for certain ophthalmological prostheses. Prior authorization also is required for most items not in the indices.

12.d Eff. 3-1-86 Eyeglasses. When frames and lenses services are provided by the same provider, prior authorization is required to exceed the following limitations in a 12 month period: one original pair; one unchanged prescription replacement pair; and one replacement pair with a documented changed prescription meeting Department criteria. Tinted lenses, occupational frames, certain glass and lens types and frames and other vision materials not obtained through the volume purchase plan also require prior authorization. Anti-glare coating, spare eyeglasses and sunglasses, and services provided primarily for convenience or cosmetic reasons are not covered.

13.d Eff. 1-1-93 Rehabilitative Services

Community Support Program Services. Community Support Programs (CSP) provide a compendium of medical and psychosocial/ rehabilitative services, enabling the recipient to better manage the symptoms of his/her illness, to improve independence, and to achieve effective levels of functioning in the community. Recipients able to benefit from mental health treatment and restorative services provided in a community setting on a long-term basis will experience a reduction in the incidence and duration of institutional care they might otherwise need.

An MA recipient who is eligible for these services has a diagnosed, severe long-term illness which puts the person at significant risk of continued institutionalization. The recipient is seriously impaired in the basic areas of everyday functioning, and traditional mental health outpatient treatment on a regular basis for at least a year has proven ineffective.

13.d Community Support Program Services. (Continued)

Agencies providing MA CSP services must be certified by the Department of Health and Social Services. Certification requires that direct supervision of treatment staff providing services is performed by a clinical coordinator who has appropriate education and clinical experience with long-term mentally ill persons; a psychiatrist must be available to provide direction and necessary psychiatric services; an in-depth assessment is completed within 30 days; and a comprehensive treatment plan is developed and reviewed at least every six months.

Services are focused on increasing the recipient's ability to gain and maintain normal functioning in the community and at home. Following in-depth assessment and mental health treatment planning, rehabilitative treatment and activities are structured to ameliorate the effects of illness on the recipient's ability to perform personal care and social activities of every-day living. Restorative care is provided to enable the recipient to seek and maintain employment; to obtain necessary medical, legal, financial and governmental services; and to acquire and maintain adequate housing. In addition, a medical treatment component affords family, individual and group psychotherapy, medication administration and monitoring, 24-hour crises intervention, and ongoing psychiatric and psychological evaluation. Finally, community support program services include case management ongoing monitoring and service coordination activities. The majority of psychosocial/rehabilitative treatment activities as well as medical treatment is provided in the community or the recipient's home to afford maximum support for the recipient in meeting treatment goals.

A recipient may not receive other psychotherapy or outpatient mental health services available under the Plan if the person is receiving CSP services. Services not covered under this category include: services to residents of SNFs, ICFs, IMDs and hospital patients unless the services are performed to prepare the recipient for discharge to reside in the community; services related to specific job seeking and placement activities; services performed by volunteers; and recreation.

CSP services may include Clozapine management. See description under 6d. Other Practitioners.

Eff. 10-1-96

13.d Mental Health Crisis Intervention Services

Mental Health Crisis Intervention (MHCI) services are a coordinated system of mental health services that provides an immediate response to assist a person experiencing a mental health crisis. "Crisis" means a situation caused by an individual's apparent mental disorder:

- that results in a high level of stress or anxiety for the individual, for the persons providing care for the individual or for the public, and
- that cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual.

An initial assessment and referral to services, if appropriate, either over the telephone or face-to-face is available to any recipient contacting a MHCI provider. Additional crisis linkage, follow-up and stabilization services are available only to recipients determined to be in crisis. Services are described in a response plan or a crisis plan for individuals known to require periodic crisis intervention, and are approved by a psychiatrist or a licensed psychologist. Interventions are designed to relieve the recipient's immediate distress, reduce the risk of escalation, reduce the risk of physical harm to the recipient or others, resolve the crisis and improve individual and family coping skills, coordinate the involvement of other resources needed to respond to the crisis and assist the recipient to make the transition to the least restrictive level of care required. Services may be provided in the office setting, over the telephone, in the home or in the community. Services to individuals residing in a hospital or nursing facility are limited to development of the response plan or crisis plan and those services required to assist the recipient to transition to the least restrictive level of care required, but may not duplicate the hospital's or nursing facility's discharge planning activities. Services may be provided directly to the recipient or to others involved with the recipient when such intervention is required to address the recipient's crisis. Services for individuals receiving Medicaid Community Support Program (CSP) services are allowed when:

- The crisis intervention program has a formal arrangement with the CSP to provide crisis services to CSP enrollees.
- The crisis intervention services are delivered according to a crisis plan developed by the crisis intervention program *and* the CSP.
- The crisis intervention services do not duplicate CSP services.

Substitute page received 3-7-97

Supplement 1 to Attachment 3.1A
State Wisconsin

While MHCI services are available in each county, agencies providing Medicaid MHCI services must be certified by the Department's Division of Supportive Living certification standards which include staff qualifications, supervision requirements, service standards and requirements for a coordinated emergency mental health services plan. Services must be available 24 hours a day, 7 days a week.

Services billed and reimbursed as MHCI services may not also be billed and reimbursed as another MA service, such as hospital outpatient services, community support program services, day treatment services, outpatient psychotherapy services or case management services. Room and board costs are not covered under MHCI services. Services that are primarily social or recreational are not covered under MHCI services.

Substitute page received 3-7-97

Eff. 1-1-93

Medical Day Treatment - Mental Health Service. Medical day treatment is a mental health rehabilitation service for recipients who are seriously impaired in basic areas of everyday functioning and for whom less intensive, traditional, outpatient mental health treatment is not adequate to stabilize their condition, attain their best possible functional level, or maintain their residence in the community. This service also is appropriate on a limited basis for individuals in hospitals or nursing facilities who are in transition from an institutional to a community setting. Day treatment services are necessary for the maximum reduction of a recipient's disability and for restoring a recipient to his or her best possible functional level.

Medical day treatment is a compendium of medical, mental health, occupational therapy, and other services. Specific day treatment services include individual and group occupational therapy and psychotherapy, medication management, symptom management, psychosocial rehabilitation services, and nursing services. Medical Assistance pays only for those medically-necessary services in a physician-approved plan of care, provided under the general direction of a physician.

Medical day treatment is provided by day treatment programs certified by the Department of Health and Social Services. Certification requires the following: a registered nurse or occupational therapist is on duty to participate in program planning, implementation, and coordination; the program is directed by an interdisciplinary team; a qualified professional staff person participates in all groups; and periodic evaluation is conducted of each recipient's progress in the program.

Prior authorization is required after a limited number of hours of service have been provided in a calendar year. Any occupational therapy and psychotherapy provided as part of the day treatment program are part of the day treatment benefit, are subject to day treatment limitations, and cannot be separately billed.

13.d Medical Day Treatment - Mental Health Service. (Continued)

Activities such as recreation, arts and crafts, music, exercise, socializing, and general education that may be part of a recipient's day treatment program, are non-covered services.

Eff. 1-1-93 Outpatient Psychotherapy Services. The Medical Assistance Program covers outpatient psychotherapy services necessary for the maximum reduction of a recipient's disability and for restoring a recipient to his or her best possible functional level. These services are available to recipients when prescribed by a physician prior to beginning treatment.

Evaluations, assessments and testing are provided to all recipients to determine the need for psychotherapy services or to evaluate the appropriateness of the services being provided. Treatment services include individual, group, and family psychotherapy (including such modalities as hypnotherapy and biofeedback) and collateral contacts. Psychiatric medication management may be provided by physicians or registered nurses employed by a certified clinic.

Outpatient psychotherapy services are provided under the direction of a psychiatrist or licensed psychologist who is listed or eligible to be listed in the National Register of Healthcare Providers in Psychology. These services may be performed by either such a psychiatrist or psychologist, or by an individual with a master's degree in social work, counseling, psychology, or a related discipline, who has 3000 hours of post-degree experience providing psychotherapy services and who is supervised by a provider meeting the certification requirements. Masters level providers must work in an outpatient clinic certified by the Department of Health and Social Services.

Prior authorization is required for recipients to receive services beyond an identified dollar or hourly limit in a calendar year. (This threshold also includes outpatient AODA services provided to the same recipient.) Evaluations require prior authorization after reaching an hourly limit in a two year period.

Eff. 10-1-97 Mental health services, including services provided by a psychiatrist, may be provided to an individual who is 21 years of age or older in the individual's home or in the community.

13.d Eff. 1-1-93 Outpatient Alcohol and Other Drug Abuse (AODA) Treatment Services.

Outpatient AODA treatment services are available to recipients when such services are necessary for the maximum reduction of the recipient's disability and for restoring the recipient to his or her best possible functional level. A physician's prescription is required before starting AODA treatment services.

Outpatient AODA services include evaluations, assessments and diagnostic services to determine the need for AODA services or to evaluate the appropriateness of the services being provided. The outpatient AODA treatment services include individual, group, and family AODA treatment and AODA educational programming specific to medical aspects of AODA diagnosis and treatment.

Medication management may be provided by physicians, or registered nurses employed by a certified clinic. Counseling services include counseling necessary to ensure the best possible level of functioning associated with methadone maintenance. All services are provided under the general direction of a physician.

These services may be performed only by the following providers: a physician; a licensed psychologist who is listed or eligible to be listed in the National Register of Healthcare Providers in Psychology; an individual with a master's degree in social work, counseling or psychology, or a related discipline, who has 3000 hours of post-degree experience providing psychotherapy services supervised by a provider meeting the certification requirements; or an individual certified by the Wisconsin Alcoholism and Drug Abuse Counselor Certification Board as an alcohol and drug counselor II or III. Masters level providers and AODA counselors must work in outpatient clinics certified by the Department of Health and Social Services.

13.d Outpatient Alcohol and Other Drug Abuse (AODA) Treatment Services. (Continued)

Prior authorization is required for AODA treatment services after the recipient has received a specified dollar or hourly limit of services in a calendar year. (This threshold also includes outpatient psychotherapy services provided to the same recipient.) Detoxification is not covered in a social (non-hospital) setting.

Eff. 10-1-97 Alcohol and other drug abuse services may be provided to an individual who is 21 years of age or older in the individual's home or in the community.

Eff. 1-1-93 Alcohol and Other Drug Abuse (AODA) Day Treatment. AODA day treatment is available for recipients who are seriously impaired in basic areas of everyday functioning and for whom less intensive, traditional, outpatient treatment is not adequate to stabilize their condition or attain their best possible functional level in the community. AODA day treatment may be appropriate for individuals who have had inpatient hospital detoxification or limited inpatient hospital rehabilitation. These services are necessary for the maximum reduction of the recipient's disability and for restoring the recipient to his or her best possible functional level.

AODA day treatment is a compendium of medical and AODA treatment services, but Medical Assistance pays for only those services which are medically necessary based on a supervising physician or psychologist-approved plan of care and are provided under the general direction of a physician. Medical Assistance-covered services include individual, group, and family therapy and educational programming specific to medical aspects of AODA diagnosis and treatment.

AODA day treatment is provided by day treatment programs certified by the Department of Health and Social Services. Certification requires that the program be directed by an interdisciplinary team; that an individual certified by the Wisconsin Alcoholism and Drug Abuse Counselor Certification Board as an alcohol and drug counselor II or III is on duty all hours in which services are provided; and that recipients are evaluated for their ability to benefit from treatment.

13.d Alcohol and Other Drug Abuse (AODA) Day Treatment. (Continued)

All AODA day treatment services must be prior authorized except for the initial three hours of assessment. A recipient may not receive outpatient AODA services during the period he or she is receiving AODA day treatment.

Activities such as recreation, arts and crafts, music, exercise, socializing and general education which may be part of the recipient's day treatment program are non-covered services by Medical Assistance.

14. Eff. 7-1-87 Services for Individuals Age 65 - In Institutions for Mental Diseases. Prior authorization and other limitations which otherwise are required for SNF or ICF care apply here. See Item #4a of this section and HSS 107.09, Wis. Adm. Code.

17. Eff. 10-1-93 Nurse Midwife Services. Nurse midwife services are subject to limitations within the scope of practice of the nurse midwife. The scope of practice is the overall management of care of a woman in normal childbirth and the provision of prenatal, intrapartal, postpartal and nonsurgical contraceptive methods and care for the mother and the newborn up to one year of age. These services include medical services delegated by a licensed physician through protocols, pursuant to the requirements set forth in the Wisconsin Nursing Act and the guidelines set forth by the medical examining board and the board of nursing. Nurse midwife services are subject to the same limitations imposed on physician services under item #5 to enable the Department to monitor and regulate the following: medical necessity, cost, frequency and place of service.

18. Eff. 7-1-88 1-1-91 Hospice Care Services. This service is provided according to federal requirements, including amendment by P.L. 101-508 (OBRA '90).

19. Eff. 10-1-97 Case Management Services.

Case Management is not available to any recipient:

a. participating in a home and community based (1915(c)) waiver program,

b. residing in an MA funded institution (e.g., hospital or nursing home), except for discharge-related case management services prior to discharge from an institutional setting,

c. in excess of one assessment or case plan per calendar year, per county, except when recipients receive prenatal care coordination,

d. in excess of one claim for ongoing monitoring per month per county except when recipients receive prenatal care coordination, or

e. enrolled in a MA-certified community support program.

Case Management does not include:

a. services which are diagnostic or therapeutic or which could be paid for by MA as any other covered benefit by certified or certifiable professionals,
b. legal advocacy by a lawyer or paralegal,
c. personal care or supportive home care,
d. client education and training, or
e. services not provided or directed towards some specific recipient.

19.b. Eff. 7-1-95 Special Tuberculosis Related Services under Section 1902(z)(2)(F)

These services are limited to those recipients with a TB-related diagnosis and include directly observed therapy, in-home monitoring of TB-symptoms, patient education and anticipatory guidance, and disposable supplies to encourage the completion of prescribed drugs.

20. Eff. 9-1-87 Extended Services for Pregnant Women

Major Categories of Service

Major categories of services are: inpatient and outpatient hospital services, physician services, laboratory and x-ray services, rural health and other clinic services, and diagnostic services. These include routine prenatal care, labor and delivery, routine post-partum care and complications of pregnancy or delivery likely to affect the pregnancy. These services are subject to the same limitations which pertain to the respective areas of service.

Eff. 1-1-93 Health Education

Health education for high risk pregnant and postpartum women (up to 60 days after delivery) is medically necessary instruction to ameliorate a pregnant woman's identified risk factors, as determined by the Department-sanctioned risk assessment. The following areas may be included:

1. education/assistance to stop smoking and to stop alcohol and addictive drug consumption;
2. education/assistance to stop potentially dangerous sexual practices;
3. lifestyle management and reproductive health;
4. education/assistance to handle environmental/ occupational hazards;
5. childbirth and parenting education.

Nutrition Counseling

Nutrition counseling for high risk pregnant and postpartum women (up to 60 days after delivery) is medically necessary nutrition instruction and guidance to ameliorate a pregnant woman's identified risk factors as determined by the Department-sanctioned risk assessment, and may include, but is not limited to, the following areas:

1. weight and weight gain;
2. biochemical and dietary factors;
3. previous and current nutrition-related obstetrical complications;
4. psychological problems affecting nutrition; and
5. reproductive history affecting nutritional status.

21. Eff. 9-1-87 Ambulatory Prenatal Care for Pregnant Women. These services are subject to the same limitations which pertain to the respective areas of service.

22. Eff. 1-1-99 Respiratory Care Services. Prior authorization of services is required for reimbursement. The recipient will have been medically dependent on a ventilator for life support for at least 6 hours per day. In addition, the recipient will meet one of the following two conditions:

- The recipient will have been so dependent for at least 30 consecutive days as an inpatient in one or more hospitals, nursing facilities, or ICF/MR, as stated in 42 CFR 440.185(a)(2).
- If the recipient has been hospitalized for less than 30 days, the recipient's eligibility for services will be determined by the Division's Chief Medical Officer on a case-by-case basis, and may include discussions with the recipient's pulmonologist and/or primary care physician to evaluate the recipient's prognosis, history of hospitalizations for the respiratory condition, diagnosis, and weaning attempts, when appropriate.

Reimbursement under the respiratory care benefit is not available for services that are part of the rental agreement for a ventilator or other necessary equipment with a durable medical equipment provider. Respite services are not covered.

23. Eff. 4-1-93 Pediatric or Family Nurse Practitioner Services. Services are subject to limitations imposed on specific disciplines within the scope of practice of the nurse. These services include medical services delegated by a licensed physician through protocols, pursuant to the requirements set forth in the Wisconsin Nursing Act and the guidelines set forth by the medical examining board and the board of nursing. Other practitioner services are subject to the same limitations imposed on physician services under item #5 to enable the Department to monitor and regulate the following: medical necessity, cost, frequency and place of service.

Medication management includes in-home administration of medications other than those given intravenously, prefilling syringes for self injection when the recipient is not capable, setting up medications for self-administration, and programming dispensers. Instructing the recipient may be covered when provided in conjunction with these activities but not covered if it is the only activity.

24. Any Other Medical Care

a. Transportation Services Non-emergency transportation by air and water ambulance requires prior authorization. Ambulance service restrictions include, but are not limited to: medical order requirements for non-emergency services, trip purpose limitations, and pick-up and destination point limitations.

Specialized motor vehicle transportation services are provided only to recipients with prescriptions documenting their inability to use common carrier transportation (such as private auto, bus, taxi). Eligibility standards are established for second attendant services. Within Department-established restrictions, unloaded mileage is a covered service utilizing specified mileage zones. Trips over a specified upper mileage limit require prior authorization.

b. Transportation for School-Based Services (SBS):

1. Transportation to School.

A child's transportation to and from a school certified as an SBS provider is a covered service only if all of the following conditions are met:

- The child receives covered SBS services identified in the child's IEP at the school on the day the transportation is provided.
- The SBS provider is financially responsible for providing the transportation.
- The child's medical need for the particular type of transportation is identified in the IEP.
- The vehicle is equipped with and the child requires a ramp or lift, an aide is present and the child requires the aide's assistance in the vehicle or the child has behavioral problems that do not require the assistance of an aide but that preclude the child from riding on a standard school bus.

Effective 1-1-98

2. Off-site transportation. A child's transportation to and from a site other than the child's "home" school is a covered service only if all of the following conditions are met:

   - The child receives covered SBS services identified in the child's IEP at the site on the day the transportation is provided.
   - The SBS provider is financially responsible for providing the transportation.
   - The transportation is either from the school to an off-site provider and back to school or to home, or is between home and a "special" school. A "special school" is a school that requires that a child have a disability in order to be enrolled, including but not limited to the Wisconsin School For The Deaf or the Wisconsin School For The Visually Handicapped, as defined in ch. PI 12, Wis. Adm. Code.

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c. Care and Services provided in a Christian Science Sanatoria. Services are covered only to the extent that they are the equivalent of the inpatient services furnished by a hospital or skilled nursing facility.

d. Nursing Facility Services for Recipients Under 21 Years of Age. The plan of care and independent medical review provide bases for authorization and payment amount.

e. Non-Emergency Out-of-State Treatment. Prior authorization is required for all non-emergency out-of-state procedures unless the provider has been granted border status.

24.f. Eff. 2-25-94 Personal Care Services. Prior authorization is required for personal care services after a limited number of hours of service have been provided in a calendar year.

Services must be supervised by an RN who reviews the plan of care, the performance of the personal care worker and evaluates the recipient's condition at least every 60 days. Reimbursement for RN supervisory visits is limited to one visit per month.

Eff. 1-1-89 Personal care workers can perform home health aide tasks when delegation, training and supervision criteria are met. Housekeeping tasks performed by the personal care worker are limited to 1/3 of the time spent in the recipient's home.

Eff. 1-1-98

HealthCheck (EPSDT) Other Services

In addition to services provided elsewhere in this Plan, HealthCheck (EPSDT) recipients may receive, if medically necessary and prior authorized, the following services:

1. Mental Health
   a. In-home psychotherapy
   b. Mental health day treatment
   c. Specialized psychological evaluation for conditions, such as children with sexually deviant behavior, where a limited number of providers are qualified. The evaluation includes components not included under outpatient psychotherapy services.
2. Dental
   a. Oral examinations exceeding the limitations for adults
   b. Single unit crowns
3. Otherwise Non-Covered Over-the-Counter Medications

   Certain commonly required medications such as multivitamins require only a prescription and not prior authorization.

1915(i) State plan Home and Community-Based Services

Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. **Services.** *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

HCBS Psychosocial Rehabilitation

2. **Statewideness.** *(Select one)*:

○	The State implements the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.
●	The State implements this benefit without regard to the statewideness requirements in §1902(a)(1) of the Act. State plan HCBS will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. *(Specify the areas to which this option applies)*:
	Services will be available in the following Wisconsin counties: Adams, Barron, Buffalo, Chippewa, Clark, Dane, Dodge, Dunn, Eau Claire, Forest, Green, Green Lake, Jackson, Jefferson, Kenosha, LaCrosse, Langlade, Lincoln, Marathon, Milwaukee, Monroe, Oneida, Ozaukee, Pepin, Pierce, Portage, Richland, Rock, Sheboygan, St. Croix, Trempealeau, Vernon, Vilas, Washington, Waukesha, Wood

3 **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** *(Select one)*:

●	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:	
	○ The Medical Assistance Unit *(name of unit)*:	
	● Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	Department of Health Services Division of Mental Health and Substance Abuse Services, Bureau of Prevention, Treatment and Recovery
○	The State plan HCBS benefit is operated by *(name of agency)*	
	A separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

4. Distribution of State plan HCBS Operational and Administrative Functions.

X *(By checking this box the State assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☑
2 State plan HCBS enrollment managed against approved limits, if any	☑	☐	☐	☑
3 Eligibility evaluation	☑	☐	☐	☑
4 Review of participant service plans	☑	☐		☐
5 Prior authorization of State plan HCBS	☑	☐	☐	☐
6 Utilization management	☑	☐		☑
7 Qualified provider enrollment	☑	☐	☐	☑
8 Execution of Medicaid provider agreement	☑	☐	☐	☑
9 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☑	☐
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
11 Quality assurance and quality improvement activities	☑	☐		☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Numbers 1, 2, 3, 6, 7 and 8 are performed by County Human Services Departments or in a few counties a Department of Community Programs that has a specific focus on persons with mental illness and/or developmental disabilities in addition to the SMA. Number 9 has been completed under contract with The Public Consulting Group.

(By checking the following boxes the State assures that):

5. X **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

6. X **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. X **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. X **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	1/16/10	9/30/10	1077
Year 2			
Year 3			
Year 4			
Year 5			

2. [X] **Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

3. **Optional Annual Limit on Number Served.** *(Select one):*

○	The State does not limit the number of individuals served during the year or at any one time. **Skip to next section.**
●	The State chooses to limit the number of *(check each that applies):*

☐ Unduplicated individuals served during the year. *(Specify in column **A** below):*

X Individuals served at any one time ("slots"). *(Specify in column **B** below):*

Annual Period	From	To	A Maximum Number served annually *(Specify):*	B Maximum Number served at any one time *(Specify):*
Year 1	1/16/10	9/30/10		938
Year 2				
Year 3				
Year 4				
Year 5				

☐ The State chooses to further schedule limits within the above annual period(s). *(Specify):*

4. **Waiting List.** *(Select one only if the State has chosen to implement an optional annual limit on the number served):*

○	The State will not maintain a waiting list.
●	The State will maintain a single list for entrance to the State plan HCBS benefit. State-established selection policies: are based on objective criteria; meet requirements of the Americans with Disabilities Act and all Medicaid regulations; and ensure that only individuals enrolled in the State plan HCBS benefit receive State plan HCBS once they leave/are taken off of the waiting list.

Financial Eligibility

1. [X] **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

2. **Medically Needy.** *(Select one):*

○	The State does not provide State plan HCBS to the medically needy.
●	The State provides State plan HCBS to the medically needy *(select one):*
○	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
●	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual according to the requirements of 42 CFR §441.556(a)(1) through (5). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*select one*):

●	Directly by the Medicaid agency
○	By Other (*specify State agency or entity with contract with the State Medicaid agency*):

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified as defined in 42 CFR §441.568. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The1915(i) program will use Wisconsin's Functional Eligibility Screen for Mental Health and Mental Health & AODA (Co-Occurring) Services in doing the independent evaluation of needs based criteria. This will be conducted by a trained certified screen administrator. Certified screeners are knowledgeable about mental health issues, interviewing skills needed to gather information, conducting a holistic dialogue, recovery-based best practices, including learning what the person needs help with within a larger, recovery-focused dialogue that includes the person's strengths, values, goals and perspectives. All persons administering the functional screen must meet the following conditions:

1. Meet the following **minimum criteria for education and experience**:
- Nursing license or a BA or BS, preferably in a health or human services related field, and at least one year of experience working with people with chronic needs, or
- Prior approval from the Department based on a combination of post-secondary education and experience or on a written plan for formal and on-the-job training to develop the required expertise; and
2. Meet all **training requirements** as specified by the Department. Currently that means:
- Completing the online course, or
- Attending an in-person training by Department staff (or watching video of same), **and**
- Reading and following screen instructions.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Wisconsin's Mental Health and AODA functional screen has been in use since 2005 to identify individual's functional needs. The screen has three sections: Community living skills inventory, crisis and situational factors (factors such as a history of inpatient stays, emergency detentions, suicide attempts etc.) and risk factors (substance use, housing instability etc.). The functional screen is web based and can be completed only by certified screeners. The needs based eligibility criteria are incorporated into the screen logic to provide an automated determination of eligibility or ineligibility. The functional screen will be completed annually. Screen reports are available showing when annual screens are due or are late.

4. X **Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

Wisconsin's 1915(i) needs based criteria requires an individual to have a variety of combinations of risk factors and functional need for assistance with community living skills such that those needs cannot be met by an outpatient clinic service. ("Assistance" is defined as including any kind of support from another person (monitoring, supervising, reminders, verbal cueing, or hands-on assistance) needed because of a physical, cognitive, or mental health condition disorder)
The following is the minimum possible combinations of factors that demonstrate 1915i eligibility:

The criteria for eligibility group seven (the lowest level of eligibility) are that the individual's needs can not be met by an outpatient clinic service plus they meet the following:

- Applicant meets at least one Eligibility Group Two criteria

OR

- Applicant meets at least one Eligibility Group Three criteria

-AND-

At least 3 of the following are true for the applicant

- Needs assistance to work or to find work less than monthly OR needs assistance with schooling less than monthly
- Needs help with home hazards 1 to 4 times a month
- Needs help to use effective social/interpersonal skills
- Needs help with money management 1 to 4 times a month
- Needs help with maintaining basic nutrition 1 to 4 times a month
- Needs help with transportation because person cannot drive due to physical, psychiatric or cognitive impairment.

Group Two eligibility criteria normally require two of the following but any one of these criteria meets the first part of the group seven requirement.

- Needs help in maintaining basic safety
- Needs assistance to manage psychiatric symptoms more than once a week
- Needs assistance with taking medications 2 to 6 days per week OR needs monitoring medication effects 2 to 6 days per week
- Has required use of emergency rooms, crisis intervention or detox units 4 or more time in the past year OR has had 1 to 3 psychiatric inpatient stays within the past year OR has had 1 to 3 emergency detentions within the past year
- Has had 4 or more psychiatric inpatient stays within the past 13 months to 3 years OR has made 4 or more suicide attempts within the past 13 months to 3 years
- Has had incidents of physical aggression 4 or more times within the past year OR has had involvement with the corrections system 4 or more times within the past year

Group 3 eligibility requires three of the following but for Group seven only one of the following is sufficient to meet the first part of the eligibility.

- Needs assistance to work more than 1 time per week
- Needs help with home hazards more than once a week
- Needs help with money management more than once a week
- Needs help with basic nutrition more than once a week
- Needs help performing general health maintenance at least 1 to 4 times a month
- Needs help managing psychiatric symptoms 1 to 4 times a month

- Needs assistance with taking medications 1 to 4 days a month or needs monitoring medication effects 1 to 4 days a month
- Has required use of emergency rooms, crisis intervention, or detox units at least 1 time in the past year; or has had 1 to 3 psychiatric inpatient stays within the past year
- Has required use of emergency rooms, crisis intervention, or detox units 4 or more times within the past 13 months to 3 years; OR has had at least 1 psychiatric inpatient stay within the past 13 months to 3 years OR has made at least one suicide attempt within the past 13 months to 3 years.
- Has had at least 1 emergency detention within the past 13 months to 3 years
- Has had at least 1 incident of physical aggression in the past year; OR has had involvement with the correctional system 4 or more times within the past 13 months to 3 years
- Currently homeless (on the street or no permanent address) OR has been evicted 2 or more times in the past year; OR homeless more than half of the time in the past year; OR currently homeless, not in transitional housing OR in Transitional Housing – Mental Health, Substance Abuse or Corrections System
- Has demonstrated self-injurious behaviors within the past year; OR has demonstrated self-injurious behaviors 13 months to 3 years ago
- Has at least one Substance-Related diagnosis except nicotine dependence or other related disorder; OR in the past 12 months, person has experienced negative consequences in legal (including OWI), financial, family, relational, or health domains that are linked to substance use

5. X **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
The needs based eligibility criteria are described in #4.	Wisconsin Law allows reimbursement to nursing homes for eligible persons who require skilled, intermediate, or limited levels of nursing care. Wis. Stat. § 49.45(6m)(i). Those levels are defined in Wis. Adm. Code § DHS 132.13. Wisconsin's BC waiver criteria for nursing home level of care are as follows: A person is functionally eligible at the nursing home level if the person requires ongoing care, assistance or supervision from another person, as is evidenced by any of the following findings from application of the functional screening: 1. The person cannot safely or appropriately perform 3 or more activities of daily living. 2. The person cannot safely or appropriately perform 2 or more ADLs and one or more instrumental activities of daily living. 3. The person cannot safely or appropriately perform 5 or more IADLs.	ICF_MR referred to in Wisconsin as FDD (Facility serving people with developmental disabilities) Wis. Adm. Code § DHS 134.13 contains the following definitions: **(13)** "FDD" or "facility serving people with developmental disabilities" means a residential facility with a capacity of 4 or more individuals who need and receive active treatment and health services as needed. **(2)** "Active treatment" means an ongoing, aggressive and consistently applied program of training and treatment services to allow the client to function as independently as possible and maintain his or her maximum functional	For inpatient hospital psychiatric emergency detention or involuntary commitment, state statutes require that: 1) The individual is mentally ill, drug dependent, or developmentally disabled; 2) The individual presents an immediate danger of harm to self or others based on a recent act or omission; and 3) Inpatient hospitalization is the least restrictive placement consistent with the requirements of the individual (i.e., the individual's needs can only be met on an inpatient basis). IMD hospital admissions nearly always occur on an emergency detention or involuntary commitment basis. For a voluntary admission (to a psychiatric unit of a general hospital), the inpatient services must: 1) Directed by a

		abilities. **(9)** "Developmental disability" means mental retardation or a related condition such as cerebral palsy, epilepsy or autism, but excluding mental illness and infirmities of aging, which is: (a) Manifested before the individual reaches age 22; (b) Likely to continue indefinitely; and (c) Results in substantial functional limitations in 3 or more of the following areas of major life activity: 1. Self-care; 2. Understanding and use of language; 3. Learning; 4. Mobility; 5. Self-direction; and 6. Capacity for independent living.	physician or dentist; and 2) Be medically necessary as certified by a physician or dentist. Among the criteria in the state definition of "medical necessity" is the requirement that the service (e.g., inpatient hospitalization) is the most appropriate level of service that can safely and effectively be provided to the recipient/individual.

*Long Term Care/Chronic Care Hospital

(By checking the following boxes the State assures that):

6. **X** **Reevaluation Schedule**. Needs-based eligibility reevaluations are conducted at least every twelve months.

7. **X** **Adjustment Authority**. The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

8. X **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

Wisconsin's 1915i services will expect recovery, outcome based services that are individualized based on the needs identified through the comprehensive assessment and person-centered planning process. This includes identifying the type of community setting most able to meet the individuals assessed support needs and individual choice. There is not an automatic placement into a service. An individual choice may require that professionals assess the housing choice and assist with recommendations for modifications that promote both independence and safety. A care manager is required to use a person centered planning process. The consumer and the care manager decide together on the appropriateness of the community setting.

The choice of the home and the decoration of personal space by the individual as well as the neighborhood are basic rights promoted through the use of person centered planning.
Opportunity to exercise personal freedom in all domains will be promoted through training of qualified staff. Participation in community events, activities and resources will be supported and limits exercised only where required to assure safety. As an example, if a person is at risk around sharp knives they would not be excluded from activities in their kitchen. Instead the knives would be stored safely. Community integration has many features and are dependent on the person's preferences and availability. Establishing choices for each person is a process of asking, learning in a trusting relationship, and providing the means to access services, supports and naturally occurring activities offered to anyone in the community at large. Many of the services offered to gain such participation will be skill building and self management strategies. Peer Specialists are often the best teachers and models supporting this type of service. They are part of the state work force to bring about system and person specific transformation.

The type of residential setting needed would be determined by the person-centered assessment. Allowable settings other than the individuals own home or apartment are Adult Family Homes (AFH), Residential care apartment complex (RCAC), and community based residential facilities (CBRF).

RCACs are by definition independent apartments with a lockable entrance and exit, a kitchen including a stove and individual bathroom, sleeping and living areas. RCAC settings are apartment complexes that offer additional services and supports to its residents. These settings are the individual's home apartment. As in any apartment setting, the owner/manager of the building may have rules or limitations to manage the building and the day to day management of the environment and services. The state has administrative rules and quality oversight that assure individuals' rights and safety in such settings.

Care Managers would be responsible for determining that AFH's offer individuals opportunity to participate in community activities. AFH's would need to offer private personal quarters or the choice of whom to share their room with and access to food and food preparation areas.

CBRF's are the most restrictive of the community residential options which is a facility that provides from 5 to 16 beds (inclusive). For this reason, only individuals whose health and safety are at risk without 24hr supervision will receive 1915(i) services in a CBRF. The care manager together with the person receiving 1915(i) services will determine that the residence is a community setting and offers opportunities for independence, choice and community integration. Wisconsin has developed standards to ensure that these facilities are community based.

Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1. X There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:

- An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified as defined in 42 CFR §441.568;
- Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
- An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care as required in 42 CFR §441.565;
- An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
- If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

2. X Based on the independent assessment, the individualized plan of care:

- Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
- Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
- Prevents the provision of unnecessary or inappropriate care;
- Identifies the State plan HCBS that the individual is assessed to need;
- Includes those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of 42 CFR §441.574(b) through (d);
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

The assessment will be completed by a care manager.

1. A care manager shall have the skills and knowledge typically acquired:

a. Through a course of study and practice experience that meets requirements for state certification/licensure as a social worker and also one year experience working with persons living with mental illness, or

b. Through a course of study leading to a BA/BS degree in a health or human services related field and one year of experience working with persons living with mental illness, or

c. Through a minimum of four years experience as a care manager, or

d. Through an equivalent combination of training and experience that equals four years of long term support and/or mental health practice in care management, or

e. The completion of a course of study leading to a degree as a registered nurse and one year employment working with persons living with mental illness.

2. The care manager shall be knowledgeable of person centered planning, the service delivery system, the needs of persons living with mental illness, and the availability of mental health recovery focused services and resources or the need for such services and resources to be developed.

3. Providers of care management are subject to the required criminal, caregiver and licensing background checks and hiring prohibitions as prescribed by the SMA.

4. **Responsibility for Plan of Care Development**. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

The service plan will be developed by the care manager with the participant and other appropriate parties determined appropriate by the participant.

1. A care manager shall have the skills and knowledge typically acquired:

a. Through a course of study and practice experience that meets requirements for state certification/licensure as a social worker and also one year experience working with persons living with mental illness, or

b. Through a course of study leading to a BA/BS degree in a health or human services related field and one year of experience working with persons living with mental illness, or

c. Through a minimum of four years experience as a care manager, or

d. Through an equivalent combination of training and experience that equals four years of long term support and/or mental health practice in care management, or

e. The completion of a course of study leading to a degree as a registered nurse and one year employment working with persons living with mental illness.

2. The care manager shall be knowledgeable of person centered planning, the service delivery system, the needs of persons living with mental illness, and the availability of mental health recovery focused services and resources or the need for such services and resources to be developed.

3. Providers of care management are subject to the required criminal, caregiver and licensing background checks and hiring prohibitions as prescribed by the SMA.

5. **Supporting the Participant in Plan of Care Development**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The care manager will provide information both verbally and in writing to the participant about the person-centered planning process, their opportunity to include others to participate in the planning, the services available through the program and that they will be able to select qualified service providers of their choice. The care manager will ensure that the participant and others they choose are fully involved in the plan development. Service plan meetings are conducted at times and places that are convenient for the participant. The care manager will document on the service plan those in attendance at the plan development. The care manager will ensure that the participant and legal representative sign and date the service plan and that they receive a copy of the completed plan.

6. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

The care manager will provide information and answer questions before and during the service plan development about the qualified service providers available to meet the assessed needs of the participant. The care manager will assist the participant in contacting and /or visiting the service provider to determine if they are a good match. On an ongoing basis thereafter, the care manager will assist the participant in interactions with service providers, including but not limited to selecting different providers who may prove to be a better match for them. All willing providers will have the opportunity to register with the DHS. The care manager will assist the person on an ongoing basis to assure that the service plan continues to meet their needs.

7. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

The care manager will submit the completed and signed service plan to the DHS. Services are not authorized until DHS has approved the service plan.

8. **Maintenance of Plan of Care Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

X	Medicaid agency		Operating agency	X	Case manager
☐	Other (*specify):*				

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Psychosocial Rehabilitation
Service Definition (Scope):	

Community Living Supportive Services (CLSS)

This service covers activities necessary to allow individuals to live with maximum independence in community integrated housing. Activities are intended to assure successful community living through utilization of skills training, cuing and/or supervision as identified by the person-centered assessment. Community Living supportive services consist of meal planning/preparation, household cleaning, personal hygiene, reminders for medications and monitoring symptoms and side effects, teaching parenting skills, community resource access and utilization, emotional regulation skills, crisis coping skills, shopping, transportation, recovery management skills and education, financial management, social and recreational activities, and developing and enhancing interpersonal skills. CLSS tasks, such as meal planning, cleaning, etc. are not done for the individual, but rather they are delivered through training, cueing, and supervision to help the participant become more independent in doing these tasks.

Wisconsin would make these services available in a variety of community locations that encompass residential, business, social and recreational settings. Residential settings are limited to an individual's own apartment or house, supported apartment programs, adult family homes (AFH), residential care apartment complexes (RCAC), and community based residential facilities (CBRF's) of from 5 to 16 beds (inclusive). The type of residential setting needed would be as agreed upon in the person-centered assessment. Individuals needing services in a CBRF setting would be those whose health and safety are at risk without 24hr supervision. Payment is not made for room and board including the cost of building maintenance.

The services provided under 1915(i) will not be duplicative of other State Plan services, including but not limited to personal care and transportation.

Supported employment

This service covers activities necessary to assist individuals to obtain and maintain competitive employment. This service may be provided by a supported employment program agency or individual employment specialist. The service will follow the Individual Placement and Support (IPS) model recognized by SAMHSA to be an evidence-based practice. This model has been shown to be effective in helping individuals obtain and maintain competitive employment. This promotes recovery through a community integrated socially valued role and increased financial independence. The core principles of this supported employment approach are:

- Participation is based on consumer choice. No one is excluded because of prior work history, hospitalization history, substance use, symptoms, or other characteristics. No one is excluded who wants to participate.
- Supported employment is closely integrated with mental health treatment. Employment specialists meet frequently with the mental health treatment team to coordinate plans.
- Competitive employment is the goal. The focus is community jobs anyone can apply for that pay at least minimum wage, including part-time and full-time jobs.
- Job search starts soon after a consumer expresses an interest in working. There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences (like pre-vocational work units, transitional employment, or sheltered workshops).
- Follow-along Supports are Continuous. Individualized supports to maintain employment continue as long as the consumer wants assistance.
- Consumer preferences are important. Choices and decisions about work and support are individualized based on the person's preferences, strengths, and experiences.

The service covers supported employment intake, assessment (not general 1915(i) intake and assessment), job development, job placement, work related symptom management, employment crisis support, and follow-along supports by an employment specialist. It also covers employment specialist time spent with the individual's mental health treatment team and Vocational Rehabilitation (VR) counselor. The Wisconsin 1915(i) HCB services will not duplicate other State Plan services. The Supported employment service does not include services available as defined in S4 (a) (4) of the 1975 Amendments to the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a State or local educational agency and vocational rehabilitation services which are otherwise available to the individual through a program funded under S110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

Peer Supports Individuals trained and certified as Peer Specialists serve as advocates, provide information and peer support for consumers in outpatient and other community settings. All consumers receiving 1915(i) peer support services will reside in home and community settings. Certified Peer Specialists perform a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process. Peer Specialists function as role models demonstrating techniques in recovery and in ongoing coping skills through: (a) offering effective recovery-based services; (b) assisting consumers in finding self-help groups; (c) assisting consumers in obtaining services that suit that individual's recovery needs; (d) teaching problem solving techniques; (e) teaching consumers how to identify and combat negative self-talk and how to identify and overcome fears; (f)assisting consumers in building social skills in the community that will enhance integration opportunities; (g) lending their unique insight into mental illness and what makes recovery possible; (h) attending treatment team and crisis plan development meetings to promote consumer's use of self-directed recovery tools; (i) informing consumers about community and natural supports and how to utilize these in the recovery process; and (j)assisting consumers in developing empowerment skills through self-advocacy and stigma-busting activities. 1915(i) HCBS will not duplicate other State Plan services.
Additional needs-based criteria for receiving the service, if applicable *(specify):*
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*
☐ Categorically needy *(specify limits):*
☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Community Living Supportive Services:			
➢ **Adult Family Homes (AFH)**	WI Statute Chapter 50 and Administrative Rule DHS 88 for 3-4 bed Adult Homes		Providers are subject to the required caregiver, criminal and licensing background checks. 15 hrs of training related to fire safety, first aid, health, safety and welfare of residents, resident rights, and treatment.
➢ **Community Based Residential Facility (CBRF)**	WI Statute Chapter 50 and Administrative Rule DHS 83 for 5 to 16 beds		Providers are subject to the required caregiver, criminal and licensing background checks. Orientation and ongoing training required that includes: training on job responsibilities, prevention and reporting of resident abuse, neglect, assessing needs and individual services, emergency and disaster plans and evacuation procedures, recognizing and responding to resident changes of condition, fire safety, first aid and choking, medication safety, standard precautions, resident rights, recognizing, preventing and responding to challenging behaviors.
➢ **Residential Care Apartment Complex (RCAC)**	WI Statute Chapter 50 and Administrative Rule DHS 89		Providers are subject to the required caregiver, criminal and licensing background checks. Training required in the services the staff are assigned; safety procedures, including fire safety, first aid, universal precautions and the facilities emergency plan, tenant rights and privacy, autonomy and independence, physical, functional and psychological characteristics of the tenant population.
➢ **Supportive Home Care Agency , Home Health Agency or Individual**	WI Statute Chapter 50, Administrative Rule DHS 133.	Administrative Code DHS 105.17.	Providers are subject to the required caregiver, criminal and licensing background checks. Orientation to job duties, policies of agency, information on other community agencies, ethics, confidentiality of patient information and patients' rights, prevention of infections. Continuing education required as appropriate to job.
➢ **Household/Chore Services Agency or Individual**			Providers are subject to caregiver, criminal and licensing background checks. Orientation for job duties, polices of agency, information about other community agencies, ethics, confidentiality of patient information, patients' rights, infection control and continuing education as required by duties.

Supported Employment:			
➢ **Supported Employment Program or Individual Employment Specialist**			One year experience working with persons living with mental illness and IPS Supported Employment Specialists Competencies developed by Dartmouth (09/09).
Peer Supports:			
➢ **Peer Specialist Agency or Individual**		Certification that the Peer Specialist has successfully completed an approved training course and that they have passed the competency based exam.	Providers are subject to caregiver, criminal and licensing background checks. Curricula of Wisconsin approved Certified Peer Specialist training include cultural competence, consumer rights, ethics and boundaries, crisis planning, trauma-informed care, and specifics to the peer specialist's role. Peer specialists will be supervised by a mental health professional.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Adult Family Homes (AFH)	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Community Based Residential Facility (CBRF)	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Residential Care Apartment Complex (RCAC)	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Supportive Home Care Agency or Individual	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Household/Chore Services Agency or Individual	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Supported Employment Prog. or Individual Employment Specialist	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Peer Specialist Agency/Individual	**County/Tribal Agency – Human Service Department or Department of Community Programs,** **Human Service Department Care Manager**	**Every other year** **Ongoing oversight & monitoring**

Service Delivery Method. (*Check each that applies*):			
☐	Participant-directed	X	Provider managed

2. X **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS ; (b) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Wisconsin's 1915(i) program will be consistent with the DHS HCBS 1915 c waiver programs in regards to payment for State plan HCBS furnished by relatives, legally responsible individuals and legal guardians. Thus the following limitations will be followed. Legal guardians, spouses of 1915(i) participants or the parents of minor children who are 1915 (i) participants will not be paid for providing any service. However, county/tribal agencies may choose to reimburse those persons for services provided to 1915(i) participants using other funding sources. Relatives not falling under the above exceptions may provide HCBS services in the quantity and to the extent determined by the needs of the consumer as specified in the individual assessment and care plan.

Oversight of this policy will be part of the on-going quality review of the person centered plan of care and provider qualifications conducted on an ongoing basis by the DHS. Further provider qualifications review will occur at the annual review process.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

X	The State does not offer opportunity for participant-direction of State plan HCBS.
O	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
O	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. *(Specify criteria):*

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

O	Participant direction is available in all geographic areas in which State plan HCBS are available.
O	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the State affected by this option):*

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. **Financial Management.** (*Select one):*

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). *(Select one):*

○	The State does not offer opportunity for participant-employer authority.
○	Participants may elect participant-employer Authority *(Check each that applies):*
	☐ **Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide 1915 (i) services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐ **Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide 1915 (i) services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget). *(Select one):*

○	The State does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):*

Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities** *(agency or entity)*	**Frequency**	**Remediation Responsibil-ities** *(Who does this)*	**Frequency** *of Analysis and Aggregation*
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	1. Service plans will reflect the use of the person-centered planning approach.	1. All (100%) initial and updated service plans will be reviewed when submitted by the provider.	1. DHS (SMA)	1. Ongoing	1. DHS (SMA)	1. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	2. Participants choice of providers will be documented in the service plan by the case manager.	2. All (100%) service plans will be reviewed for documentation of participant choice of providers	2. DHS (SMA)	2. Annually	2. DHS (SMA)	2. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	3. Interviews of participant satisfaction will be conducted.	3. Representative sampling of interview results will be reviewed and put into a summary report. The State's sampling methodology will ensure a 95 percent confidence	3. DHS (SMA)	3. Annually or at disenrollment	3. DHS (SMA)	3. If a corrective action plan is needed it must be provided within 15 days

		level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.				and the state will respond in 15 days for a total of 30 days.
	4. Participant needs assessment conducted by the case manager.	4. Representative sampling of case files will be reviewed. The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.	4. DHS (SMA)	4. Annually	4. DHS (SMA)	4. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	5. All willing providers have the opportunity to register with the DHS.	5. Representative sampling of service plans will be reviewed. The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.	5. DHS (SMA)	5. Annually	5. DHS (SMA)	5. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.

	6. Services are delivered in accordance with the service plan.	_6. Representative sampling of services delivered will be reviewed . The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.	6. DHS (SMA)	6. Annually	6. DHS (SMA)	6. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
Providers meet required qualifications.	1. All providers meet requirements established by DHS and documented by the case manager. 2. All providers have a current agreement with the SMA.	1. Representative sampling of case files will be reviewed. The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population. 2. Presence of MA agreement in sampling of case records. The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of	1. DHS (SMA) 2. DHS (SMA)	1. Annually 2. Annually	1. DHS (SMA) 2. DHS (SMA)	1. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days. 2. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.

		approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.				

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities** *(agency or entity)*	**Frequency**	**Remediation Responsibil-ities** *(Who does this)*	**Frequency** *of Analysis and Aggregation*
The SMA retains authority and responsibility for program operations and oversight.	1. Case files will reflect that local non-state entities and providers adhere to federal and state program requirements, policies and regulations for 1915i program. 2. Presence of the county entities entering accurate information into the automated functional screen.	1. Representative sampling record reviews of case files, mental health functional screen, service provider records, monitoring reports and on-site interviews. The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population. 2. All (100%) initial and updated automated functional screens will be reviewed when service plan packets are submitted by the county entity.	1. DHS (SMA) 2. DHS (SMA	1. Annually 2. Ongoing	1. DHS (SMA) 2. DHS (SMA	1. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days. 2. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15

						days for a total of 30 days.
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	1. DHS oversight through the MMIS system to assure claims are coded and paid in accordance with the state plan.	1. MMIS Reports	1. DHS (SMA)	1. Ongoing	1. DHS (SMA)	1. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days
	2. Representative sample of claims, case files and service plans.	2. Program review of MMIS Reports, documentation of sample selection process.	2. DHS (SMA)	2. Annually	2. DHS (SMA)	2. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days
	3. Claims are authorized and furnished appropriately.	3. Program testing in annual single audit of county agency.	3. DHS (SMA)	3. Annually	3. DHS (SMA)	3. If a corrective action plan is needed it must be provided within 45 days and the state will respond in 45 days for a total of 90 days
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	1. Service plans address health and welfare needs of the participant.	1. Representative sampling record reviews of case files, service plans and outcomes, mental health functional screen, service provider records, monitoring reports and on-site interviews. The State's sampling methodology will ensure	1. DHS (SMA)	1. Annually	1. DHS (SMA)	1. Immediate safety issues identified must have a corrective action plan within 3 days. If a corrective

		a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.				action plan is needed that is not urgent, it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	2. Providers will complete and submit incident reports as required by DHS policy.	2. All (100%) of incident reports will be reviewed to ensure appropriate actions have been taken. Adverse incidents are reported to the county case manager (CM). The CM reviews the situation and takes steps to protect safety of participant. The CM immediately notifies, as appropriate, the DHS Division of Quality Assurance. The CM also notifies the state 1915(i) coordinator. All critical incidents tracked by the state 1915(i) coordinator who will follow-up as needed. Coordinator will review incidents for any patterns that would suggest the need for further investigation or technical assistance.	2. DHS (SMA)	2. Ongoing	2. County Agency and DHS (SMA)	2. Reported to care manager within 24 hrs. Reported to state within 3 days with corrective action plan. State reviews plan and responds within 10 days. Formal report submitted by county to state on outcome of corrective action in 30 days.
	3. CLSS providers supply medication reminders to participants and monitor their signs and symptoms and side-effects.	3. Representative sampling record reviews of case files, service provider records, monitoring reports and on-site interviews. The State's sampling methodology will ensure a 95 percent confidence	3. DHS (SMA)	3. Annually	3. DHS (SMA)	3. Immediate safety issues identified must have a corrective action plan within 3 days.

		level with a 5 percent margin of error (confidence interval). The sample will be drawn from the population of 1915(i) CLSS recipients, and not the universal 1915(i) population				If a corrective action plan is needed that is not urgent, it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.

System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
1. The automated functional screen provides a great deal of information regarding individuals' functioning. Wisconsin intends to compare the initial screen to subsequent annual screens. We expect to see decreases in a variety of indicators such as ER use, inpatient stays, emergency detentions, physical aggression, and housing instability. Previous analysis of this data with other MH programs has demonstrated a high degree of statistical significance.	This analysis will be done by the DHS (SMA)	Annually	1. Counties with a high rate on one of these indicators that does not show comparable decreases over time will be asked to develop a Quality Improvement project around that indicator. Counties will be expected to maintain data to track improvements from the changes they make and to continue to make adjustments until they see an improvement in the specific indicator.
2. Adverse incident reports will also be tracked	DHS (SMA)	Annually	2. Counties with a pattern of incident reports may be asked to obtain training and/or implement a quality improvement project as appropriate. If patterns of adverse incident reports are noted across counties, the state will provide training to address those issues.